111 S. Whittier
Wichita, Kansas 67207

Client Information Form

Name:_____Date:_____

Age:_____

Date of Birth:_____

Social Security No.:_____

Address:_____City_____State_____Zip_____

Phone #:_____Email_____

How did you find out about my practice? _____

Primary Care Physician:
_____Address:_____

Physician's Phone:_____

Do you want me to let your physician know that you are a client? Yes _____No_____

Please list psychotropic medications you are taking: _____ None _____

Medication	Dosage	Physician Prescribing
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list when and where you have had treatment before: _____ None

Dates Place

_____ _____

_____ _____

_____ _____

_____ _____

Substance Use History:

If you drink alcohol, indicate frequency, amount and date of last use:
:_____

_____

What street drugs have you used? Indicate any IV use and last use of each: _____

_____

_____

_____

General Health and Mental Health Information

1. How would you rate your current physical health? (please circle)

   Poor Unsatisfactory Satisfactory Good Very good

2. On the average, how many hours of sleep are you getting a night? _____ hours
3. On the average, which best describes you sleeping pattern?

   _____ I get to sleep pretty good, but wake up frequently

   _____ My mind races and can't get to sleep for quite awhile

   _____ I get to sleep fairly quickly but I don't stay asleep.

   _____ I sleep but I don't get good sleep.

Any other description: _____

_____

4. How many days a week do you exercise? _____
5. What kind of exercise do you do? _____
6. What kind of eating problems do you have, if any: _____None
   _____
   _____
7. Are you experiencing sadness, grief or depression? _____Yes _____No
   If you are experiencing depression please rate on a 10 point scale the severity, 10 being very severe: _____
   How long have you been experiencing sadness, grief or depression? _____
8. Are you currently experiencing anxiety? _____ Yes _____No On the average, please rate on a 10 point scale the severity, 10 being very severe: _____
   How long have you been experiencing anxiety? _____
9. Are you experiencing panic attacks? _____ Yes _____No
   How long have you been experiencing panic attacks? _____
10. Are you currently in a romantic relationship? _____ Yes _____ No Please rate your relationship on a scale of one to 10, ten being very good: _____
11. How high is your stress on a 10 point scale, ten being overwhelming: _____

Family Mental Health History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, grandmother, uncle etc.)

	Please Circle	List Family Member
Substance abuse (Prescription, alcohol/drugs	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	

Suicide Attempts yes/no

Harm History:

Have you ever attempted suicide? ____Yes _____No If yes, how many attempts? _____ When was the last attempt? _____

Are you experiencing suicidal thoughts now? _____ Yes _____No

Are you concerned about someone could harm you? (consider stalking, phone harassment, domestic violence, verbal threats etc.) _____ Yes _____ No

Have you ever been sexually abused: _____ Yes _____ No

Have you ever been physically abused (objects thrown at you, hit, slapped etc.) _____ Yes _____ No

Do you feel safe most of the time? _____ Yes _____ No

Substance Use

Have / do you use alcohol? _____ Yes _____No If so, average amount used per using episode:_____

Have / do you use illicit drugs? _____Yes _____No Please list ones you have used. or are using. (This information is completely held in confidence and can't be released to anyone without your written consent.)

Drug	Date of Last use
_____	_____
_____	_____
_____	_____
_____	_____

If you have been or are an IV user have you been tested for HIV, Hepatitis A, B, and C. _____Yes _____No

Has the use of any of the above substances caused negative consequences for you: ___Yes ___No

Have you ever been in a substance abuse treatment center (outpatient/inpatient): ___Yes ___ No

Self Assessment:

1. What do you consider to be your strengths?

2. What do you consider to be your weaknesses?

3. What would you like to accomplish with therapy/counseling?